

Dr. David N. Block Family Chiropractor
Dr. Mindal R. Donner Family Chiropractor
Patient Information

Name(First, Middle, Last) _____ Date _____

Address(no PO boxes) _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

How do you prefer your electronic appointment reminder, email or text? _____

For text reminders, please list your cell phone carrier (AT&T, Verizon, T-Mobile, Sprint, etc) _____

Social Security # _____ E-mail address _____

Age _____ Birthdate ____/____/____ Sex M / F Status M S W D No.Children _____

Occupation _____ Employer _____ Years Employed _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____ S.S.# _____

Primary Insurance Plan Name _____ ID# _____ Group# _____

Policy Holder's Name _____ Relationship to policy holder: Spouse ___ Child ___ Self ___

Policy Holder's Birthdate _____

Secondary Insurance Plan Name _____ ID# _____ Group # _____

Is your condition due to an auto accident? Yes ___ No ___ If yes, what state? _____

Is your condition work related? Yes ___ No ___ Is your condition related to another accident? Yes ___ No ___

What is your deductible _____ Was it met? Yes ___ No ___ Unsure ___

If no, it will be paid by Cash _____ Check _____ Credit Card _____ Other _____

Immediate Family under care in this clinic _____

I understand that the above patient is a minor and I personally guarantee payment for all charges related to:

(patient name) _____ Name of guarantor: _____

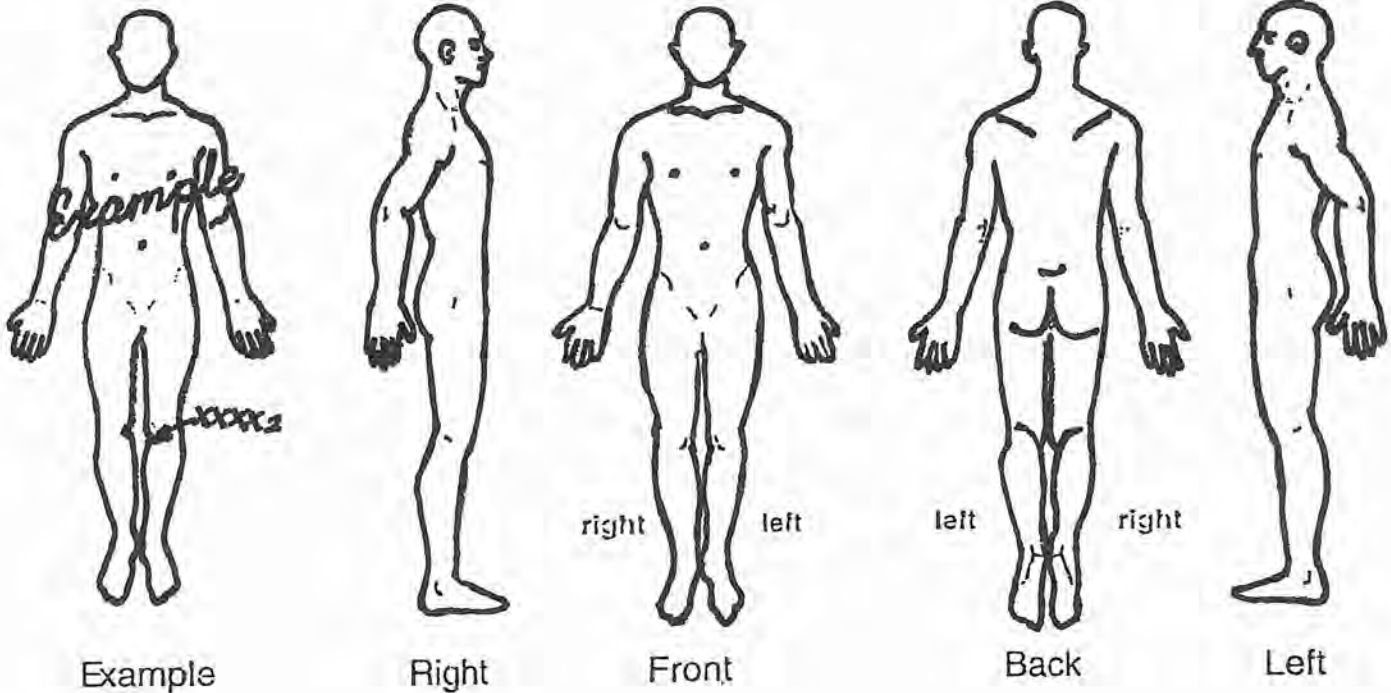
Signature of guarantor: _____ Date: _____

With my signature below, I authorize the assignment of insurance benefits directly to Dr. David N. Block.

Patient/Guarantor Signature: _____ Date: _____

Show Us Where It Hurts:

In the diagram below, please draw an arrow pointing to the area(s) of your pain or condition:



Authorization for Care, Insurance Assignment & Fees Please read and sign

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that Dr. David N. Block Family Chiropractic will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. David N. Block, Inc will be credited to my account on receipt (insurance assignment of benefits). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment as well as collection manager/attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. Interest rate on unpaid balances is the greater of 1.65% per month or \$5.00 per month and begins from the time an account has been considered delinquent. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I also authorize the doctor to bill any unpaid balance to my credit card if it was used previously in the office to pay for services rendered, to obtain a credit report if deemed necessary and verify my employment should that information be needed in the collection of unpaid balances.

I hereby authorize the doctor to provide for me manual adjustments to my spine and therapy. The patient also agrees that he/she is responsible for all bills incurred at this office including interest on unpaid balances. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Name _____

Date _____

Patient Signature _____

Date _____

Guardian/Spouse/or Guarantor's Name Authorizing Care _____ Date: _____

Guardian/Spouse/or Guarantor's Signature Authorizing Care _____ Date: _____

CURRENT HEALTH CONDITION: Name _____

Date: _____

- **Please describe your pain or health problem** - including where you feel the pain, how often you feel it, and what you think may have caused it: _____

- **Which best describes your discomfort?** ache sharp/stabbing burning pins & needles numbness
- **Rate how much it bothers you - on a scale of 1 (discomfort) to 10 (extreme pain)** _____
- **What activities/positions/etc. makes it feel worse?** _____
- **What makes it feel better?** _____
- **Does your current condition ever cause you to be:** moody irritable unpleasant depressed angry
- **What is your occupation?** _____ **How does your condition interfere with your work?**
 decreased productivity hard to concentrate can't work without pain had to stop working/disabled
- **What activities have you been forced to stop or hesitate doing because of your condition?**
 athletic/exercise activities household work - lifting, etc. gardening walking biking dancing
 running lovemaking other (please list): _____
- **Check any of the following drugs & treatments you have used unsuccessfully to get rid of this problem:**
 Tylenol Advil aspirin Aleve Motrin antacids sinus medicine blood pressure pills
 Muscle relaxers ice heat massage herbal or remedies ben-gay or other ointments
 pain medicine injections prescription pain medicine (please list): _____
 bed rest other (please list): _____
- **Check off any tests or evaluations you have had for this condition(s):**
 x-ray MRI CAT scan bone scan blood tests other _____
- **Check off any type of doctors you've consulted for this condition(s):**
 general medical physician orthopedist's neurologist rheumatologist cardiologist's
 dermatologist podiatrist dentist pediatrician psychiatrist allergist Ob/Gyn herbalist
 gastrointestinal/internal medicine urologist oncologist ophthalmologist pain clinic
 lung specialist ear, nose & throat sports medicine physical therapist osteopath physiatrist
 other chiropractor(s): Who? _____
How long and often did you go? _____ When was your last appointment? _____

PAST HEALTH HISTORY - Check any of the following conditions you have ever had:

- Pneumonia Mumps Influenza Rheumatic Fever Small Pox Pleurisy Polio Chicken Pox
 - Arthritis Tuberculosis Diabetes Epilepsy Whooping Cough Cancer Mental Disorders
 - Measles Thyroid Eczema Psoriasis Tonsillitis Tested HIV positive
 - **Have you ever had any surgery?** yes no Type: _____
 - **Have you ever been hospitalized?** yes no Why? _____
 - **Please list all medications currently taking** _____
- Please describe any other pertinent health information you are aware of:**

General Health History

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OVER THE PAST 6 MONTHS

General Symptoms

- Headaches/Migraines
- Allergies
- Sleeping Problems
- Frequent Colds/Flu
- Fever/Chills

Muscle & Skeletal System

- Low Back Pain
- Pain Between Shoulders
- Neck Pain/Stiffness
- Shoulder/Elbow/Arm Pain
- Hand/Wrist/Finger Pain
- Walking Problems
- Hip/Leg Pain/Sciatica
- Foot Pain
- Jaw Pain or Clicking
- Difficulty Chewing

Nerve System

- Numbness - Where?
- Cold/Tingling Extremities - Where?
- Weakness/Paralysis - Where?
- Dizziness
- Confusion/Depression
- Seizures/Convulsions
- Face Pain/Tic Doulareaux
- Hyperactivity

Gastro-intestinal System

- Abdominal Pain/Cramps
- Heartburn/Indigestion
- Hiatal Hernia
- Constipation
- Diarrhea
- Gas/Bloating
- Nausea/Vomiting
- Hemorrhoids
- Colitis
- Black/Bloody Stool
- Liver Problems/Jaundice
- Gall Bladder Problems
- Poor/Excessive Appetite
- Excessive Thirst

Cardiovascular & Respiratory Systems

- Breathing Difficulty/Wheezing/Asthma
- Lung Problems/Congestion/Cough
- Chest Pain
- Heart/Artery Disease
- Circulation Problems
- Irregular Heartbeat
- Blood Pressure Problems
- Varicose Veins
- Ankle Swelling
- Stroke

Eyes - Ears - Nose - Throat

- Vision Problems
- Crossed Eyes
- Hearing Difficulty
- Sore Throat/Laryngitis
- Chronic Stuffed/Runny Nose
- Sinus Problems/Infections/Headaches
- Nose Bleeds
- Itchy/Watery Eyes
- Enlarged Glands
- Loss of Smell or Taste Perception
- Ear Aches/Noises/Infection

Urinary System

- Pain or Burning Upon Urination
- Discolored Urine
- Excessive Urination Frequency
- Urinary Hesitancy
- Kidney Disorders
- Bladder Disorders
- Bed-Wetting/Incontinence

For Men Only:

- Impotence
- Prostate Disorders

For Women Only:

- PMS
- Menstrual Cramps
- Menstrual Irregularity
- Vaginal Pain
- Yeast Infection
- Breast Pain/Lumps
- Menopause Symptoms
- Infertility

Date of your last menstrual period _____

Are you Pregnant?

- Yes No Not Sure

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____ Birth Date: ____ / ____ / ____

Preferred Language?

- English
- Spanish
- Other _____

Height: _____ feet _____ inches

Weight: _____ lbs

Phone #: _____

Race?

- I do not wish to provide this information.
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other _____

Zip Code: _____

Ethnicity?

- I do not wish to provide this information.
- Hispanic or Latino
- Non-Hispanic or Non-Latino
- Other _____

Smoking Status?

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Do you have any medication allergies?

- No known medication allergies
- Yes. What? _____

Are you currently taking any medications?

- Not currently prescribed any medications
- Yes...
 - What? _____ mg
 - What? _____ mg
 - What? _____ mg

Last known blood pressure reading? ____ / ____

If unknown was it normal? _____

Are you medicated for blood pressure? _____

Block Family Chiropractic
1108 Madison Plaza Chesapeake VA 23320
(757) 436-5428/ (757) 436-5325

AUTHORIZATION FOR TEXT MESSAGING (SMS COMMUNICATIONS)

Patient Name _____ Date of Birth: _____

I understand that:

- Text messages are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number up to date with Block Family Chiropractic.
- I should not send PHI or ePHI to Block Family Chiropractic in a text message because of the unsecure nature of text messages.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Block Family Chiropractic to send text messages to the following mobile number: _____ for the following:
- Block Family Chiropractic will not send PHI a text message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by text message, phone call, or email address.
- My wireless carrier is: AT&T Sprint T-Mobile Verizon Other: _____

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature _____ Date _____

Print Name _____ Relationship to Patient _____

Definitions:

Protected Health Information (PHI): PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.